**Title 20—DEPARTMENT OF INSURANCE,
FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 100—Insurer Conduct
Chapter 1—Improper or Unfair Claims Settlement
Practices**

ORDER OF RULEMAKING

By the authority vested in the Department of Insurance, Financial Institutions and Professional Registration under sections 375.045 and 376.1007, RSMo 2000 and sections 376.383 and 376.384, RSMo Supp. 2007, the director adopts a rule as follows.

20 CSR 100-1.060 is adopted.

A notice of the proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on October 15, 2008 (33 MoReg 1877 – 1879). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: A public hearing on this proposed rule was held November 18, 2008, and the public comment period ended November 25, 2008. At the public hearing, department staff explained the new rule and the director received comments from Coventry Health Care of Kansas, Inc., United Health Group, CVS Caremark, Pharmaceutical Care Management Association (PCMA), America's Health Insurance Plans (AHIP), Signature Medical Group, Medco Health Solutions, Inc. (Medco), Express Scripts, and Missouri State Medical Association (MSMA).

COMMENT #1: CVS Caremark, the Pharmaceutical Care Management Association (PCMA), United Health Group, America's Health Insurance Plans (AHIP), Coventry Health Care of Kansas, Inc. (Coventry), Medco Health Solutions, Inc. (Medco), and Express Scripts all commented on the proposed language in 20 CSR 100-1.060(4)(A). CVS Caremark, PCMA, Medco, and Express Scripts all expressed concern that the proposed language would require payment of a claim with ten (10) days of receipt contrary to §376.383, RSMo. AHIP and Coventry Health Care of Kansas, Inc. both expressed concern that the regulation was inconsistent with the language of §376.383, RSMo, requiring a health carrier to (1) Send an acknowledgment of the date of receipt; or (2) Send notice of the status of the claim that includes a request for additional information within ten (10) days of receiving a claim. United Health Group appeared to find the language confusing and sought clarification.
RESPONSE: Although the director does not believe the current language of the proposed regulation requires payment of a claim within 10 (ten) days as suggested, it is clear from the comments that some clarification of the language would be appropriate. Accordingly, the director will modify the proposed rule to clarify that all of the actions listed in 20 CSR 100-1.060(4)(A) are in the alternative.

COMMENT #2: United Health Group commented that the definition of "Request for additional information" is more restrictive than §376.383.10, RSMo, in that the information requested may be needed to determine a company's liability but may not be specific to the claim or episode of care or may not be in the patient's medical or billing record, as defined by the proposed 20 CSR 100-1.060(2)(M)1. and 4. As such, United Health Group requested that the provisions in 20 CSR 100-1.060(2)(M)1. and 4. be removed.
RESPONSE: The director agrees and will modify the rule accordingly.

COMMENT #3: United Health Group requested that the phrase "or indirectly" be removed from the definition of "third-party contractor" in 20 CSR 100-1.060(2)(P). Coventry Health Care of

Kansas, Inc. expressed a similar concern. The concern expressed by United Health Group was that the proposed language might be interpreted to make it responsible for the actions of a provider's contractor. United Health Group suggests the following change to the current language of the proposed rule: "'Third-party contractor' shall mean an entity or person directly ~~or indirectly~~ contracted with the health carrier to receive or process claims for reimbursement of health care services **on behalf of the health carrier.**"
RESPONSE: While it was not the intent of the proposed language to make health carriers responsible for the actions of providers' contractors, the director appreciates United Health Group's concern. Therefore, the language of the definition in the proposed regulation will be modified to more closely conform to the definition contained in §376.383, RSMo.

COMMENT #4: United Health Group suggested that the director add language to 20 CSR 100-1.060(4)(B) to clarify that it must be able to identify the claimant as an insured before it accepts the claim and sends an acknowledgement of the claim. It suggested rewording this subsection to read as follows:

> If notice of the claim was received **and accepted** as an electronically filed claim, the health carrier shall issue confirmation of receipt of the claim within one (1) working day of its receipt to the claimant **or third-party contractor** that submitted the claim electronically.

RESPONSE: The director appreciates this comment. Nothing in the authorizing statutes requires that a claim be "accepted" in order to be "received." However, the proposed rule will be modified to make the language consistent with the definition of "Confirmation of receipt" found in 20 CSR 100-1.060(2)(C). Additionally, subparagraph 20 CSR 100-1.060(3)(B)3. will be removed since it seems to be redundant with this paragraph.

COMMENT #5: United Health Group suggested that the director should add language to 20 CSR 100-1.060(4)(D) to clarify that providers are not always the ones who submit claims; that they often submit claims through third-party contractors. It suggested rewording this subsection to read as follows: All denials, suspensions, or requests for additional information shall be communicated in writing to the claimant **or third-party contractor** and shall include specific reasons why the action was taken or why the information is needed.
RESPONSE: The director appreciates this comment, but feels that United Health Group misunderstood the meaning of the defined term, "third-party contractor." Under §376.383.1(9), RSMo, and this proposed rule, a "third-party contractor" is a person or entity "contracted with the health carrier to receive or process claims." Consequently, the suggested change will not be made.

COMMENT #6: United Health Group suggested that to keep the language of the rule consistent, 20 CSR 100-1.060(5)(A)1. be modified as follows: "... The interest shall be payable by the health carrier to the health care provider, individual insured, **enrollee,** or other entity submitting the claim...."
RESPONSE: The director agrees and will modify the rule accordingly.

COMMENT #7: America's Health Insurance Plans (AHIP) and Coventry Health Care of Kansas, Inc. commented that the reference to non-electronic claims in the proposed rule's definition of claim in subsection 20 CSR 100-1.060(2)(B) should be removed, as §376.384.2, RSMo, states

that paper claims submitted by providers shall not be subject to the provisions of §376.383, RSMo.
RESPONSE: The director agrees with these comments to the extent they relate to provider submitted claims and will modify the definition of "claim" set forth in 20 CSR 100-1.060(2)(B) accordingly.

COMMENT #8: America's Health Insurance Plans (AHIP) commented that the requirement for a carrier to submit two (2) separate requests for additional information to the claimant before suspending or denying a claim is inconsistent with §376.383, RSMo. It requests that this requirement be removed from 20 CSR 100-1.060(5).
RESPONSE: The director appreciates AHIP's comment, but believes AHIP has misunderstood the meaning of this section of the proposed regulation. The language in section (5) that AHIP cites in its comment relates only to claims that are suspended or denied due to lack of information. Section 375.1007(3), RSMo, requires companies to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies. Section 376.383.2, RSMo, further clarifies what constitutes a reasonable investigation for the purposes of health care claims by limiting to two (2) the number of requests for additional information that a health carrier is required to make – the initial request and a final request. The language in section (5) of the proposed regulation merely embodies the statutory requirements of §§375.1007(3) and 376.383.2, RSMo. Therefore, no change will be made to this portion of the proposed rule in response to this comment.

COMMENT #9: America's Health Insurance Plans (AHIP) commented that that the proposed rules do not take into account the requirements outlined in §376.427, RSMo, governing claims payment when an assignment of benefits has been made. As such, AHIP proposed the following language be added to the regulation to exclude situations that are governed by §376.427, RSMo: Notwithstanding any other provisions to the contrary, this rule shall not be construed to apply to any claim that is subject to §376.427, RMSo.
RESPONSE: The director appreciates this comment; however, no changes will be made in response. The rules of statutory construction require that statutes be read in harmony so as to give effect to each. Nothing in §376.427, RSMo, excludes claims subject to it from §§376.383 and 376.384, RSMo, and vice versa. All health carriers, as defined by §376.1350, RSMo, are bound by §§376.383 and 376.384, RSMo. The director believes that all of the statutes in question can be applied without conflict; however, in the event a conflict were found, the provisions of §§376.383 and 376.384, RSMo, would prevail since these statutes were enacted more recently than §376.427, RSMo.

COMMENT #10: Coventry Health Care of Kansas, Inc. commented that the definition of "Date of receipt," found in 20 CSR 100-1.060(2)(F) is confusing. By using the postmark date as the date of receipt by the carrier, Coventry Health Care of Kansas, Inc. argues that the rule improperly adds days against the health carrier's timeliness requirements, as there may be several days between the postmark date and the date the carrier actually receives the correspondence.
RESPONSE: The director agrees with this comment and will modify the rule accordingly.

COMMENT #11: Coventry Health Care of Kansas, Inc. commented that the definition of "Reason for Denial," as set forth in 20 CSR 100-1.060(2)(L) is incomplete and overly restrictive because it limits the reason for denial to specific contract provision(s). Coventry Health Care of Kansas, Inc. contends that this limitation would prevent a carrier from administratively denying a claim if a provider submits a duplicate claim or from denying a claim for a product or service that is not intended to be covered by the carrier, nor specifically listed as a covered service within the contract. The result of such a requirement would require a health carrier to create a specific exclusion provision for all possible products or services, or administrative scenarios, which are not intended to be covered.
RESPONSE: The director agrees with this comment and will remove the definition of "Reason for denial."

COMMENT #12: Signature Medical Group commended the director for the language proposed in subsection 20 CSR 100-1.060(2)(M), in that it will limit the scope of requests to that information which is reasonably relevant to the claims adjudication process; and will prevent abusive conduct regarding these requests. Signature Medical Group commended the director for language proposed in subsection 20 CSR 100-1.060(4)(A), in that it will clarify the requirements of §376.383, RSMo, as they relate to the health carrier's duties upon receipt of a claim.
RESPONSE: The director thanks Signature Medical Group for this comment. While some changes have been made to this language in response to previous comments, the director believes the provision will still fulfill the goals espoused by this comment.

COMMENT #13: Signature Medical Group commended the director for language proposed in subsection 20 CSR 100-1.060(4)(A), in that it will clarify the requirements of §376.383, RSMo, as they relate to the health carrier's duties upon receipt of a claim.
RESPONSE: The director thanks Signature Medical Group for this comment. While some changes have been made to this language in response to previous comments, the director believes the provision will still fulfill the goals espoused by this comment.

COMMENT #14: Signature Medical Group suggested that the rule make reference in 20 CSR 100-1.060(5)(A) to the statutory penalty set forth in §376.383.6, RSMo, for those claims on which the health carrier has notified the claimant, in writing, that the claim has been suspended or denied. Missouri State Medical Association (MSMA) made a similar comment regarding the provisions of the proposed rule and §376.383.6, RSMo.
RESPONSE: The director appreciates this comment; however, no changes were made to the rule in response. It is the director's understanding that §376.383.6, RSMo, provides a private cause of action enforceable by providers through the court system and is outside the purview of this regulation.

COMMENT #15: Signature Medical Group requested that the director further define the relevant correspondence it seeks when reviewing a complaint against a health carrier as set forth in 20 CSR 100-1.060(5)(C) in order to make the review process more efficient for the claimant/provider and the director.
RESPONSE: The director appreciates this comment; however, no changes were made to the rule in response. The director cannot determine in advance what correspondence might be relevant to

any particular complaint. It depends on the health care provider to make such a determination on a case-by-case basis, consistent with the language of the statute and this regulation.

COMMENT #16: Missouri State Medical Association (MSMA) supported the proposed rule, stating that the clarifications to §§376.383 and 376.384, RSMo, proposed by the director will facilitate compliance and enforcement of the law and its intent; however, MSMA requested that the director revise the definition of claim to address problems experienced when providers submit a multi-line claim that includes several claims for several separate services.
RESPONSE: The director appreciates this comment; however, no changes were made to the rule in response. It is the director's understanding that §376.383, RSMo, allows each line of a multi-line claim to separately be paid, denied, or additional information requested. This is envisioned in the language of the regulation as currently drafted.

20 CSR 100-1.060 Standards for Prompt, Fair, and Equitable Settlements under Health Benefit Plans

(2) Definitions. As used in sections 376.383 and 376.384, RSMo, and in the regulations promulgated pursuant thereto—

(A) "Acknowledgment of the date of receipt" shall mean a written notice, whether made in electronic or nonelectronic format, to the claimant by the health carrier or its third-party contractor that it received a claim and setting forth the date on which the claim was received;

(B) "Claim" shall mean a written request or demand by a claimant for the payment of health care services provided, whether made in an electronic format by a provider or in an electronic or nonelectronic format by an insured or enrollee;

(C) "Confirmation of receipt" shall mean a written notice, made in electronic or nonelectronic format, to the health care provider by the health carrier or its third-party contractor that it received an electronically-filed claim. A confirmation of receipt may also constitute an acknowledgement of the date of receipt if it meets the requirements of subsection (A) of this section;

(D) "Date of claim payment" shall mean the date the health carrier or its third-party contractor mails or sends the payment as indicated by the date of—

1. The postmark, if a claim payment is delivered by the U.S. Postal Service;
2. The electronic transmission, if the payment is made electronically;
3. The delivery of the claim payment by a courier; or
4. The receipt by the claimant, if the claim payment is made other than as provided in paragraphs (2)(D)1. through (2)(D)3., above;

(E) "Date of denial" shall mean the date when the health carrier or its third-party contractor mails or electronically sends a denial;

(F) "Date of receipt" shall mean the date upon which the health carrier or its third-party contractor first receives a claim or other information relevant and pertinent to the claim, indicated by the date of—

1. Presumed receipt in subsection (3)(B), below, if a claim is delivered in that manner;
2. The electronic transmission, if the claim is delivered electronically; or
3. The date stamped by the health carrier or its third-party contractor, if the claim is delivered in a manner other than those described above;

(G) "Deny" or "denial" shall mean the health carrier or its third-party contractor mails or sends an electronic or written notice to the claimant refusing to reimburse all or part of the claim, which includes each reason for the denial;

(H) "Health benefit plan" shall mean health benefit plan as defined in section 376.1350, RSMo;

(I) "Notification of claim" shall mean any notification to a carrier or its third-party contractor, by a claimant, which reasonably apprises the health carrier of the facts pertinent to a claim;

(J) "Pay" or "payment" shall mean the health carrier or its third-party contractor mails or sends electronic or written notice including remuneration to the claimant that reimburses all or part of the claim;

(K) "Processing days" shall mean the number of days the health carrier or its third-party contractor has the claim in its possession. Processing days shall not include days in which the health carrier is waiting for a response to a reasonable request for additional necessary information;

(L) "Request for additional information" shall mean when the health carrier or its third-party contractor requests, in writing, whether made in electronic or nonelectronic format, additional necessary information from the claimant to determine if all or part of the claim will be reimbursed. Such a request must meet the following requirements:

1. It shall describe with specificity the clinical and other information to be included in the response; and
2. It shall be relevant and necessary for the resolution of the claim;

(M) "Suspension date" shall mean the date the health carrier or its third-party contractor mails or sends electronic written notice that the claim is suspended;

(N) "Third-party contractor" shall mean an entity or person contracted with the health carrier to receive or process claims for reimbursement of health care services; and

(O) "Working days" shall mean the number of consecutive days not counting weekends or federal holidays.

(3) Communications Between Entities Subject to This Rule.

(A) An entity subject to this rule may deliver written communication as follows:

1. By U.S. mail, first-class delivery; by U.S. mail, return receipt requested; or by overnight mail, and maintain a copy of the receipt or signature card acknowledging receipt of delivery;

2. Electronically and maintain proof of the electronically submitted communication;

3. If the entity accepts facsimile transmissions for the type of communication being sent, then fax the communication and maintain proof of the facsimile transmission; or

4. Hand delivery of the communication and maintain a copy of the signed receipt acknowledging the hand delivery.

(B) Communication is presumed to be received as follows:

1. On the date shown by a date stamp showing the actual date received, if the sender used U.S. mail, first-class delivery; or

2. On the date the delivery receipt is signed, if the sender used an overnight delivery service or the U.S. mail, return receipt requested, or if the sender hand delivered the communication.

(4) Standards for Prompt, Fair, and Equitable Settlements under Health Benefit Plans.

(A) Every health carrier or third-party contractor, upon receiving notification of a claim from a claimant, shall, within ten (10) working days, do one (1) or more of the following—

1. Send an acknowledgment of the date of receipt;

2. Send written notice of status of the claim, whether made in electronic or nonelectronic format, with a request for additional information and from whom it is requested, such as the claimant, the patient, or another health care provider;

3. Pay the total amount of the claim in accordance with the contract between the health carrier and the health care provider or the health carrier and the insured or enrollee;

4. Pay the portion of the claim for which the health carrier acknowledges liability in accordance with the contract between the health carrier and the health care provider or the health carrier and the insured or enrollee, suspend the remainder of the claim, and send a request for additional information;

5. Pay the portion of the claim for which the health carrier acknowledges liability in accordance with the contract between the health carrier and the health care provider or the health carrier and the insured or enrollee, and deny a portion of the claim and specify each reason for the denial; or

6. Deny the claim in its entirety and specify each reason for such denial.

(B) If notice of the claim was received as an electronically filed claim, the health carrier or its third-party contractor shall issue confirmation of receipt of the claim within one (1) working day of its receipt to the claimant that submitted the claim electronically.

(C) If additional information is requested, an appropriate reply shall be made within fifteen (15) processing days of receiving any additional claim information from the person from whom the information was requested. An appropriate reply shall mean payment of all or the undisputed portion of claim, denial of the claim, suspension of the claim, or a final request for additional information.

(D) All denials, suspensions, or requests for additional information shall be communicated in writing to the claimant and shall include specific reasons why the action was taken or why the information is needed.

(5) Health carriers must conduct a reasonable investigation before denying or suspending a claim in whole or in part. Health carriers shall not suspend or deny claims for the lack of information until it has requested the pertinent additional information on two (2) separate occasions.

(A) Claims.

1. If a claim or portion of a claim remains unpaid after forty-five (45) days after notification of the claim, interest shall accrue beginning from the forty-fifth day after the date of receipt of the claim at a rate equal to one percent (1%) per month of the unpaid balance of the claim until the claim is paid. The interest shall be payable by the health carrier to the health care provider, individual insured, enrollee, or other entity submitting the claim. If the health carrier denies or suspends a claim that is subsequently determined to be the liability of the health carrier, the health carrier will be responsible for the interest from the forty-fifth day of the original date of notification of the claim until the claim is actually paid.

2. Any improperly denied claims that are subsequently determined to be payable shall have interest calculated from the forty-fifth day after the date of receipt of the claim.

3. The health carrier may wait until the claimant's aggregate interest payments reach five dollars ($5) before making interest payment to the claimant.

(B) Duties of the Health Carrier.

1. When a health carrier pays or denies a claim, it shall explain in sufficient detail how each item or service was reimbursed. Specifically, if the health carrier has a contract rate with the health care provider, the health carrier shall indicate which items or services are included in the reimbursement and which items are not included in the reimbursement.

2. Pursuant to the requirements of 20 CSR 100-8.040, health carriers shall maintain and legibly date stamp all documentary material related to the pertinent events of a claim. Pertinent events shall include, but not be limited to, the date of the notification of claim, date of claim payment, date of denial, suspension date, reason for denial or suspension, amount paid, amount denied,

amount suspended, date additional information is requested, the nature of the specific additional information requested, and the date such additional information was received.

3. After notification of a claim, if any information on the claim that affects the amount of benefits payable is changed or omitted in the processing of the claim, including any electronic edits, the health carrier or its third-party contractor shall notify the claimant of the modification in writing with specificity.

4. Any contractual agreement between the health carrier and any of its third-party contractors that receives or processes claims, obtains the service of a health care provider to provide health care services, or issues verifications or pre-authorizations may not be construed to limit the health carrier's authority or responsibility to comply with all applicable statutory and regulatory requirements of this rule or of sections 376.383 and 376.384, RSMo.

5. Contracts between health care providers, health carriers, and their respective third-party contractors shall not extend the statutory or regulatory time frames set forth in this rule or in sections 376.383 and 376.384, RSMo.

(C) Complaints Against Health Carriers. Every complaint made by a health care provider to the director shall include: the health care provider's name, address, and daytime phone number; the health carrier's name; the date of service and date(s) the claim was filed with the health carrier; all relevant correspondence between the health care provider and the health carrier, including requests from the health carrier for additional information; a copy of the confirmation of receipt or acknowledgment of the date of receipt of the claim from the health carrier or its third-party contractor, if available; and additional information which the health care provider believes would be of assistance in the department's review.